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Klein, M. D., Beck, A. F., Henize, A. W., Parrish, D. S., Fink, E. E., & Kahn, R. S. (2013). Doctors and Lawyers Collaborating to HeLP Children: Outcomes from a Successful Partnership between Professions. *Journal of Health Care for the Poor and Underserved, 24(3),* 1063-1073.

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Pettignano, R., Bliss, L. R., Caley, S. B., & McLaren, S. (2013). Can access to a medical-legal partnership benefit patients with asthma who live in an urban community? *Journal of Health Care for the Poor and Underserved, 24(2),* 706-717.

NURSES' ROLES IN HEALTHCARE LEGAL PARTNERSHIPS

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Abstract

In health care settings that serve low-income populations, healthcare legal partnerships (HLPs) are becoming a necessity in order to maximize clients' opportunities for health. Medical-Legal Partnerships (MLPs), also known as Healthcare Legal Partnerships (HLPs), add the power of law to reduce individual legal barriers and negative social determinants of health. The terms HLP and MLP are used interchangeably, though HLPs can and do include specialties and disciplines, such as dentistry, nursing, and social work, beyond those usually considered medicine. HLPs offer academic centers opportunities to enhance collaborative practice by jointly educating law and healthcare students for partnership. In the U.S., nurses are the most trusted profession in society and the largest healthcare profession. Nursing can use its diffuse presence and power to actualize the growing research suggesting HLPs can help society achieve the concurrent goals of improved care, better health, and lower per capita healthcare costs.

***Keywords*:** healthcare legal partnership, medical-legal partnership, social determinants, nurse, attorney, legal aid, low-income

INTRODUCTION

A low-income man with diabetes sees nurse practitioner Andrea Goldblaum in an urban clinic in the United States' Upper Midwest. His blood sugar levels have been rising and he begins displaying early symptoms of kidney failure to the point that he is placed on a list to receive a kidney transplant. The nurse practitioner discovers that her patient's publicly funded food stamps benefit has been unexpectedly cut by over 67% to two dollars a day, leaving him to rely mostly on rice and potatoes for his meals. Fortunately, the nurse is able to refer her patient to the staff attorney, a newer member of the

clinic's health care team. The attorney soon discovers that food stamp program administrators have not only substantially miscalculated the patient's benefits, they have made the same error with roughly 200 other food stamp recipients. The on-site collaboration between health care providers and the legal aid attorney corrects this situation and the patient sees his energy and spirits increase, his blood sugar improve, and some of his medications discontinued (Benson, 2015; Mid-Minnesota Legal Aid [MMLA], 2015).

When healthcare providers and civil law attorneys cross the distinct boundaries separating their professions and integrate their respective services for their shared clients, they can overcome negative social determinants of health. As with the case of the low-income diabetic, there is tremendous moral and financial value in using such legal services for secondary and tertiary prevention. That's even before considering the morbidity and mortality that may have been likewise prevented for the 200 additional wrongfully denied food stamps recipients. In the words of Goldblaum's colleague, physician David Councilman, “Having [legal aid] on site has become a necessity" (Benson, 2015; MMLA, 2015). Such is the power of healthcare legal partnerships (HLPs).

HEALTHCARE LEGAL PARTNERSHIPS (HLPS)

The conditions into which one is born, grows, works, lives, and ages, i.e., the social determinants of health, have a significant effect on health (Robert Wood Johnson Foundation [RWJF], 2011; World Health Organization [WHO], 2008). For many poor and low-income Americans among the 47 million who live in poverty (U.S. Census Bureau, 2014), social determinants manifest as barriers, not facilitators, to health. The Legal Services Corporation (LSC) was started in 1974 by the United States Congress to fund and monitor civil legal aid in every state and U.S. territory (in contrast to public defenders who represent clients in criminal cases). The LSC estimates that one in six low-income families have at least one civil legal problem negatively affecting their health, yet only one in five of these needs are addressed with an attorney (LSC, 2009).

Health conditions impaired by environmental and social conditions, like food insecurity, substandard housing, unjustifiable denial of public benefits, and personal safety concerns, cannot be improved by traditional medical interventions alone. The Robert Wood Johnson Foundation (RWJF) reports that 95% of physicians serving low-income urban communities say patients' social needs are as important to address as their medical conditions (2011). It follows that healthcare providers have recruited legal aid or private pro bono ("for the good") attorneys to address the civil legal needs of their clients without charge since the 1960s. Medical legal partnerships (MLPs), alternatively known as healthcare legal partnerships (HLPs), started forming in 1993. The first MLPs were initiated by pediatricians Barry Zuckerman at Boston Medical Center (BMC) in Massachusetts and Amos Deinard from the University of Minnesota's Community-University Health Care Center (CUHCC) in Minneapolis, Minnesota (Lawton, 2014; National Center for Medical-Legal Partnership [National Center], 2013; Deinard, Martin, Lindemann, and Haynes, 1997).

Nearly 300 partnerships now operate in 36 states to bridge the justice gap for low-income Americans (National Center, 2016). Although partnership arrangements vary, their goals focus on three core functions: (1) to provide legal assistance to clients, (2) to transform health and legal institutions, and (3) to achieve policy change (Beeson, McAllister, & Regenstein, 2013). Using the "I-HELP" framework, HLP teams combat the health-impacting social determinants of **i**ncome, **h**ousing, **e**ducation/**e**mployment, **l**egal status (immigration), and **p**ersonal/family stability and safety (Kenyon, Sandel, Silverstein, Shakir, & Zuckerman, 2007).

HLP structures vary. Healthcare providers can contract with legal aid attorneys to have a regular office in a clinic or they may refer patients to a legal aid office whose staff subsequently try to contact the potential clients to more fully assess their legal needs. Private law firms' pro bono attorneys and paralegals can use their donated time to partner with healthcare providers who refer patients to them; the firm's pro bono director may then assess the potential client to determine if an actionable legal problem exists (Weber & Polkey, 2015). Across the U.S., HLPs involve 152 hospitals (up

from 135 a year ago), 140 health centers (up from 127 a year ago), 36 medical, nursing, social work and public health schools (up from 35), 142 legal aid agencies (up from 127), 51 law schools (up from 46), and 71 pro bono partners (up from 70) (National Center, 2016). Their work ranges from individual client representation, interprofessional education to enhance understanding and collaboration among healthcare and legal disciplines in solving health challenges, and policy development and advocacy to improve population health by reducing negative social determinants of health.

Funding is similarly varied, cobbled together from foundations, healthcare providers, private law firms, and the publicly funded legal aid. The case for healthcare providers to fund HLPs grows as benefit denial appeals by attorneys turn uncompensated care into compensated care, for example, one million dollars recovered in previously denied claims for cancer treatment or a a 319% return on investment (ROI) over three years for a provider-funded HLP in Illinois (Beeson et al, 2013). The 2010 Patient Protection and Affordable Care Act's financial penalties on hospitals with preventable rehospitalizations, combined with the mandate that tax-exempt nonprofit hospitals regularly assess and meet community needs, suggests there are incentives for hospitals to invest in keeping people healthy in their communities (George Washington University's Maureen Byrnes, National MLP Summit, April 9, 2015).

Speaking to the important role that healthcare providers now play in assessing legal needs, nurse practitioner Sarah Rabin-Lobron of the nurse-managed Rising Sun Health Center in Philadelphia, Pennsylvania, states, "We're asking questions we didn't use to ask because now we have answers" (National Center, Oct. 27, 2014).

HLPs can improve asthma control in adults, reducing emergency room visits and rehospitalizations (O'Sullivan et al., 2012). Studies show that legal actions against non-performing landlords can reduce household environmental asthma triggers after attempts by the family and healthcare team have failed (Klein, Beck, Henize, Parrish, Fink, & Kahn, 2013; Beck, Klein, Schaffzin, Tallent, Gillam, & Kahn, 2012; Pettignano, Bliss, Caley, & McLaren, 2013). Other positive impacts include better maternal-child

outcomes, reduced child abuse, fewer missed clinic appointments, improved cancer treatment adherence, and helping patients become better advocates for their care (Beeson et al, 2013; Zuckerman, 2014).

NURSES' ROLES IN HLPS

Florence Nightingale could have been describing the evolving role of nurses in HLPs when she wrote:

> It [nursing] has been limited to signify little more than the administration of medicines and the application of poultices. It ought to signify the proper use of fresh air, light, warmth, cleanliness, quiet and the proper selection and administration of diet - all at the least expense of vital power to the patient. (1859, p. 6).

The “administration of medicines and the application of poultices” have very little collective positive impact on population health, compared to negative social determinants like substandard housing, poverty, food insecurity, discrimination, income deprivation, and disability-related impoverishment.

Nurses have a long history of caring and advocating for the same populations served by legal aid or pro bono attorneys. The profession's longstanding social contract is found in the profession’s Code of Ethics (ANA, 2015) and its Social Policy Statement (ANA, 2010). The Code of Ethics calls nurses to "practice with compassion and respect for the dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems" (ANA, 2015a). When asked why he pursued forming the U.S.'s first HLP between a freestanding dental access clinic and the local legal aid office, Bob Enger, former president of the Minnesota State Bar Association replied, "We serve the same people" (personal conversation, Oct. 30, 2015).

Common moral foundations, goals and objectives are at the heart of partnership. They can overcome historical interprofessional distrust and controversy, such as "lawyers telling [providers] what they should have done or must do, in order not to be sued by other lawyers - not a situation conducive to collaboration" (Morton, Taras, & Reznik, 2008, p.1). Morton et al. suggest that promoting trust and collaboration is facilitated by recognizing that traditionally healthcare and law professionals "were relatively autonomous, if not protective of their separate spheres of knowledge" however, "it is now time for the professions to each acknowledge and articulate the necessity of the collaborative alliances in their standards...to help cure systemic health issues. The need for such collaboration is unquestionable" (2008, p.6).

Increasingly, nurses collaborate with attorneys to reduce environmental barriers to health for individuals, families and populations. Dawn Bolyard, MSN, exemplifies this collaboration. She is a clinical nurse specialist at Mercy Children's Pulmonary Center in Toledo, Ohio, and a liaison with the legal aid attorneys from Associates for Better Legal Equality (ABLE) who partner with the Center. According to Bolyard, "The role of the nurse is to assess and plan care using all the information available to move the patient to a healthier environment" (personal communication with Bolyard and conference presentation, April 9-10, 2015). Having an HLP in a nurse's practice setting, "literally changes how you assess patients. When everyone on the team gets information, and then sits down together as partners, you get the whole picture and do better care planning." Part of the information Bolyard collects is "hot-spotting," using GIS mapping to highlight the prevalence and neighborhood intensity of health problems in Toledo. She works with her HLP's attorney, Kate Mitchell, to improve access to Medicaid funding for medications needed by babies born prematurely who struggle with respiratory illnesses. They collaborate to make sure Medicaid managed care organizations correctly apply the appropriate laws on Early and Periodic Screening, Diagnosis and Treatment (EPSDT). They convinced the federal Center for Medicare and Medicaid Services (CMS) to enforce the EPSDT laws in Ohio and to promote the retraining of administrative law judges on proper court enforcement of those laws (personal Bolyard communication and conference presentation, April 9-10, 2015).

Figure 1 includes a partial list of the many roles that nurses play in health promotion throughout society from the bedside to the boardroom and to the leadership of major government agencies. Because of the profession's breadth and tradition of going where needs exist, expanded models of HLPs might, for example, respond to possible child neglect assessed by school nurses, or vulnerability caused by delinquent landlords, or unenforced building codes assessed by home health nurses, or financial exploitation detected by nurses working in long term care.

Nurses' community presence will complement clinics where most HLPs are currently located. Partnerships that accentuate nursing's roles in the community will have a greater ability to improve lives. Funders have begun recognizing nursing's role in maximizing HLP potential. The Kresge Foundation has funded a three-year pilot for the National Nursing Centers Consortium's 250 U.S. members to incorporate MLPs in their practices (Hansen-Turton, 2013). The National Nursing Centers Consortium (NNCC) has in turn funded three nurse-led legal partnerships at nurse-managed health centers: the Nursing Center for Community Health affiliated with the University of Akron School of Nursing, a similar project at East Tennessee State University, and the Abbottsford-Falls Health Center in Philadelphia, Pennsylvania (University of Akron, 2015).

Because the HLP movement's goal to improve population health through better access to justice depends in large measure on changing public policy, the growth of nursing leadership in that arena requires attention by HLP leaders. Joanne Disch, professor ad honorem of the University of Minnesota School of Nursing, is a former board president of the commanding American Association of Retired People (AARP). Former critical care nurse Marilyn Tavenner led the federal Center for Medicare and Medicaid Services (CMS). Nurse leader Mary Wakefield ran the federal Health Resources and Services Administration (HRSA) when it included medical legal partnerships as health-facilitating "enabling services" for federally qualified health centers (FQHCs) (Bureau of Primary Health Care, 2014; National Center, 2014). The American Nurses Association lists six nurses from both major parties in Congress (2015b), and 62 nurse state legislators;

Minnesota leads with six (2015c). As Minnesota State Senator Kathy Sheran, RN, chair of that body's health policy committee asserts, "Public policy is a nursing intervention," (speech at the University of Minnesota, April 30, 2011).

The presence and diversity of over three million nurses make the profession the largest in U.S. healthcare. Nurses' strong professional ethics and social justice obligations earned them the top spot in the public's trust for 14 straight years (Gallup, 2015). Combined with the thorough knowledge and powerful moral and physical presence nurses have in promoting individual and population health with patients, families, communities, institutions and health systems, nurses are key to achieving the full HLP potential to reduce the justice gap that impairs opportunities for health.

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Figure 1. Nursing Roles to Maximize Healthcare Legal Partnerships

Role	Setting	Action
Champion	Boards. C-Suites, e.g, chief nursing officer, chief information officer, chief executive officer. Hospital committees doing Community Health Needs Assessments. Philanthropy directors. FQHC* managers. Non-profit managers. National Nursing Centers Consortium. Nurse attorneys, e.g., TAANA.** Research funders, e.g., NINR***	Changing institutional policies to include HLPs. Approving funding for HLPs. Expanding existing HLPs throughout provider system.
Care Coordinator	Hospitals, facilities and clinics. Health care homes (patient-centered medical homes). Behavioral health care homes.	Holistic needs assessment, issue-spotting and collaborative patient-centered care planning. Referrals and follow-up on impact of combined, coordinated interventions. Communication, integration and coordination among providers, patients and partners. Assuring follow-

		up appointments work for patients, e.g., transportation available.
Educator	Clinical education settings. Classrooms. Academic health centers. Certification bodies.	Prelicensure and graduate education and practice with HLPs. Interprofessional education including law students. Research. Enhance expertise in HLP use. Publications and conference presentations.
Population Health Improvement	Professional organizations. Legislatures. Government agencies. Public health. Coalitions. Non-profit organizations. Quality assurance, e.g., agencies that monitor and accredit facilities.	Data management. Population screening. EHR policy improvement. Epidemiological research. Policy analysis, development, advocacy, and implementation. Media presence.
Clinician	Hospitals. Skilled nursing facilities. Schools (K-12 and higher education). VA and military services. Employee health. Community clinics, homeless healthcare centers and FQHCs. Retail clinics, e.g., Minute Clinic. Health system	Holistic needs assessment, issue-spotting and collaborative patient-centered care planning. Referrals, referrals, referrals. Assessment of home environments and family relationships. Pre-admission assessments for skilled nursing facilities.

	primary care and specialty clinic networks. Nurse health centers. Home health. Public health clinics, e.g., immunization clinics, WIC clinics, etc. Group homes. Assisted living facilities. Telehealth.	Collaborative development of intervention protocols and "standing orders."

* FQHC: federally qualified health centers

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